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I've made the decision to see a therapist…Now what?: Top Ten Frequently Asked Questions to Ask Your Insurance Company About Your Mental Health Benefits

- **Are mental health benefits covered under my plan?**

Most - but not all - health insurance companies will pay the costs of mental health care services such as therapy and/or medication. In some cases, health insurance companies will cover more intensive services like in-patient hospitalizations or residential treatment.

- **Does my insurance company manage my family's mental health benefits or is another company "subcontracted" or "carved out" to manage my mental health benefits?**

Some health insurance companies manage both their consumer's medical and mental health benefits. However, others "subcontract" or "carve out" mental health benefits to another company. Insurance cards may have a separate telephone number to call for information regarding mental health benefits; check yours to see if there is a specific phone number for Behavioral/Mental Health and Substance Abuse Treatment. If so, you may call that number to ask about benefits.

- **Do I need a referral from my primary care physician to see a mental health professional?**

When you want to receive a particular service in a non-emergency situation, many health insurance companies, especially HMOs (Health Maintenance Organizations), require you to get a referral for that service from a primary care physician. Otherwise, your plan might not cover the cost. In some cases, the plan may allow a certain number of mental health visits with a provider without a referral, and then require a referral for additional visits beyond that number. Typically, the primary care physician's referral must be formal and in writing. Usually, s/he signs a form and faxes or emails it to the insurance company. If your primary care physician only gives you verbal approval of a service, this is not official and your insurance plan will be free to disregard it. It is prudent for you to contact your insurance company to inquire if a referral is needed for any behavioral health services along with keeping a copy of such forms for your own records.

- **Do I need pre-approval from my insurance company before I can see a mental health professional?**

Some health insurance companies, especially HMOs, require a pre-approval or preauthorization. Unlike a "referral" which comes from a doctor and means your doctor is referring you to a treatment because it is medically necessary, a pre-approval or pre-authorization means that your insurance company agrees to pay for the services. You would typically call the insurance company for initial authorization of a number of visits. Once you use the sessions that were approved in the initial authorization, you, along with your provider would need to call the insurance company again to authorize additional sessions, and would likely have to submit a form explaining why additional services are needed.

- **Are there co-payments for services?**

Co-payments are fees that consumers themselves pay when they receive health care services. It is important to understand what your co-pays are for mental health services are and to find out if there are different co-pays for “in-network” versus “out-of-network" providers. Please know co-payments for behavioral health providers (aka ‘specialists’) may/may not be different from your primary care physician. This is largely due to behavioral health providers being considered specialists and having different fee scales. You will call your insurance company to inquire about your co-payment financial responsibility

- **Can I only see providers on the list provided by my insurance (in-network) or can I choose to see any qualified professional (out-of-network)?**

Insurance plans often create contracts with certain health care professionals who are considered to be “in-network providers.” In-network providers accept payment for services from the insurance company, often at a discounted rate. If you an have an HMO, typically your insurance company will only pay for services provided by a health care professional who is a part of the its own network. If you choose to see a provider who is not in the network, then your insurance carrier will not pay for services. Insurance plans can vary considerably when it comes to this issue. For example, if you have a PPO (Preferred Provider Organization), your insurance might have a preferred network of providers, but you may still be able to see providers out-of-network. However, it is possible that your insurance company may pay for these services at a lesser rate, which means you may have higher “out-of-pocket” expenses for services.

- **If services are covered for providers who are out-of-network, are those services covered differently than services provided by in-network providers?**

As stated previously, if you learn that you do have “out-of-network” benefits included in your plan, it is important to understand at what rate such benefits are covered as compared to in-network benefits. For example, your insurance company might cover psychotherapy visits for you seeing an in-network provider and you may only be expected to cover the co-pay. However, if you choose to see an out-of-network provider, your insurance company might only pay for 60% of the total service, and thus you would be responsible for a 40% **coinsurance.** You might also have to reach a certain deductible before your insurance company would pay that 60%. Thus, seeing an out-of-network provider could prove significantly more expensive than seeing an in-network provider.

- **Do I have a deductible for services?**

Some insurance companies require that you pay a specified amount of money towards health care expenses, including mental health expenses, before they will begin covering services. The amount of this deductible can vary from plan to plan and may also be higher to see out-of-network providers versus in-network providers, if there is a deductible at all. If there is an annual deductible needing to be met before your insurance company covers any behavioral health services, if this is the case, you will need to pay ‘out-of-pocket’ for your mental health care services until you meet the amount of the deductible. When seeing an in-network provider, you will only be required to pay the in-network rate to the provider, whereas an out-of-network provider may charge a higher fee.

- **Are there visit limits, dollar limits, or other coverage limits for my mental health benefits?**

Some plans have limits on the number of psychotherapy visits or medication management visits per benefit year. For example, your plan might limit you to 24 sessions with a psychotherapist each year, and up to 7 days of inpatient treatment a year. If you exceed these services, you will have to pay out of pocket.

- **What if I have out of state insurance?**

Your plan may have compatibility with plans in Washington, DC, Maryland and Virginia, but you must call the insurance company from the state you are insured to verify compatibility.

If there are any questions or concerns please contact me via the methods detailed below:

email: admin@hopefulcounseling.org
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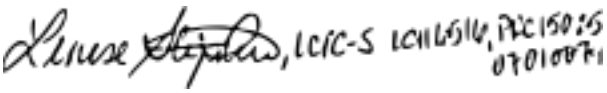
Regards,



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